Platte Dental Clinic

Name: _____
Last First MI

Maiden Name: _____Preferred Name: _____ ☐ Male ☐ Female ☐ Single ☐ Married

Address: _____ City: _____ State_____ Zip_____

SSN: _____ DOB: ____/_____/_____ Employer_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____

How did you hear about our office? _____

Dental Insurance-Primary

Policy Holder Name: _____

Policy Holder DOB: _____/_____/_____

Policy Holder SSN: _____

ID Number: _____

Policy Holder Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Group Number: _____

Payor ID Number: _____

Dental Insurance-Secondary

Policy Holder Name: _____

Policy Holder DOB: _____/_____/_____

Policy Holder SSN/ID: _____

ID Number: _____

Policy Holder Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Group Number: _____

Payor ID Number: _____

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I, undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Platte Dental Clinic, LLC all insurance benefits, if any, otherwise payable to me for services rendered.

Responsible Party Signature: _____

Relationship to Patient: _____ **Date**: _____

Platte Dental Clinic

Medical History

Are you taking any medications? · Yes · No

Please list each one: _____

Do you have a personal physician? · Yes · No

Physician's Name: _____ Date of last visit: _____

Physician's office location (city/state) _____

Are you currently undergoing treatment of a medical condition: · Yes · No

Please explain: _____

Do you use tobacco? · Yes · No

Have you had a joint replaced? · Yes · No

Have you ever taken bisphosphonates - medications to treat osteoporosis or other bone disorders? · Yes · No

In the last 2 years have you taken corticosteroids (prednisone, methylprednisolone etc.)? · Yes · No

Have you ever had any surgical procedures? · Yes · No

Please list each one: _____

Yes	No	Conditions
☐	☐	Joint Replacement
☐	☐	Artificial Heart Valve
☐	☐	Congenital Heart Defects
☐	☐	Infective Endocarditis
☐	☐	Mitral Valve Prolapse
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Pacemaker
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Angina
☐	☐	Heart Failure
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Blood Disorder
☐	☐	HIV/AIDS
☐	☐	Asthma

Yes	No	Conditions
☐	☐	Emphysema
☐	☐	COPD
☐	☐	Tuberculosis
☐	☐	Sinus Problems
☐	☐	Diabetes
☐	☐	Liver Diseases/Disorders
☐	☐	Kidney Diseases/Disorders
☐	☐	Stomach Problems/Ulcers
☐	☐	Thyroid Problems
☐	☐	Glaucoma
☐	☐	Epilepsy/Seizures
☐	☐	Psychiatric Problems
☐	☐	Anxiety
☐	☐	Alcohol/Drug Addiction
☐	☐	Rheumatoid Arthritis
☐	☐	Osteoarthritis
☐	☐	Cancer
☐	☐	Radiation Treatment/Chemotherapy

Yes	No	If female, please answer
☐	☐	Are you taking birth control pills?
☐	☐	Are you pregnant?
		If so, # of weeks? _____
☐	☐	Are you nursing?

Allergies

☐	☐	Penicillin or other Antibiotics
☐	☐	Dental Anesthetics
☐	☐	Morphine/Codeine/Hydrocodone
☐	☐	Metals
☐	☐	Acrylics
☐	☐	Latex
☐	☐	Other_____

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Dental History

Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Are you currently in pain? ☐ Yes ☐ No
Are your teeth sensitive to heat, cold, or while chewing? ☐ Yes ☐ No
Have you had any difficult extractions in the past? ☐ Yes ☐ No
Have you had any head, neck, or jaw injuries? ☐ Yes ☐ No
Do you experience any jaw pain or difficulty opening or closing? ☐ Yes ☐ No
Do you have frequent headaches? ☐ Yes ☐ No
Do you grind your teeth? ☐ Yes ☐ No
Are you happy with the appearance of your teeth? ☐ Yes ☐ No
Do you get cold sores frequently? ☐ Yes ☐ No
Do your gums bleed while brushing/flossing? ☐ Yes ☐ No
How many times do you: brush/day_____? Floss/wk? _____
Have you ever had instruction on proper brushing and flossing? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that is information will be held in the strictest confidence and it is my responsibility to inform this office of any changes of any changes in my medical status.

Signature: _____Date: _____